Name of Patient (last, first, mi)	Birthdate	Sex	Race	County of Residence	Clinic Code

ARKANSAS DEPARTMENT OF HEALTH
IMMUNIZATION RECORD

☐ Free Copy

Name and Address of Provider

Social Security Number	Does Patient Have Medicaid Number? ☐ Yes, enter number: ☐ No	Address (include street, city, zip)
Telephone Numbers Work: Home: Message:		
Name of Parent/Guardian/Responsible Adult	Birthdate of Parent/Guardian/ Responsibile Adult	Patient's Medicare Number

Insurance

Insurance Status: ☐ IP (insurance pays for shots) ☐ IDP (insurance does not pay for shots or if unknown) ☐ NI (no insurance)	Policy Number	Expiration Date	Name of Insured	Relationship to Patient ☐ Self ☐ Parent ☐ Spouse ☐ Other	Name of Insurance Company	Address of Insurance Company

Circle One

* Vaccine	Age	** VIS Title/Date	Date Vaccine Given	Dosage - Route - Site	MFG. and Lot Number	* Vaccine	Age	** VIS Title/Date	Date Vaccine Given	Dosage - Route - Site	MFG. and Lot Number
DTP/Hib						Hib					
DTP/Hib						Hib					
DTP/Hib						Hib					
DTP/Hib						Hib					
DTP/Hib						IG					
DTP DTaP DT Td						Hep B					
DTP DTaP DT Td						Hep B					
DTP DTaP DT Td						Hep B					
DTP DTaP DT Td						Hep B					
DTP DTaP DT Td						HBIG					
OPV / EIPV						Rotavirus					
OPV / EIPV						Rotavirus					
OPV / EIPV						Rotavirus					
OPV / EIPV						Hep A					
OPV / EIPV						Hep A					
MMR						Hep A					
MMR											
Varicella											
Varicella											

TB Skin Test (PPD and Multiple Puncture Test)

Date	Check (√) PPD	Check (√) MPT	Nurse	Results (mm)	Nurse	Date	Check (√) PPD	Check (√) MPT	Nurse	Results (mm)	Nurse	Date	Check (√) PPD	Check (√) MPT	Nurse	Results (mm)	Nurse

IMM-1 (R 7/97)

* *Document dates of previously administered vaccines based on proper verification.*
** *Document title and date of Vaccine Information Statement (VIS) as shown on reverse of the VIS in the lower corner.*

Circle in RED vaccines related to an adverse event (reaction). Include additional information on back in "Comments" section.